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Impact of partial participation in integrated family planning training on medical knowledge, patient communication and professionalism

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Abstract

Introduction: Obstetrics and gynecology residency programs are required to provide access to abortion training, but residents can opt out of participating for religious or moral reasons. Quantitative data suggest that most residents who opt out of doing abortions participate and gain skills in other aspects of the family planning training. However, little is known about their experience and perspective.

Methods: Between June 2010 and June 2011, we conducted semistructured interviews with current and former residents who opted out of some or all of the family planning training at ob-gyn residency programs affiliated with the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning. Residents were either self-identified or were identified by their Ryan Program directors as having opted out of some training. The interviews were transcribed and coded using modified grounded theory.

Results: Twenty-six physicians were interviewed by telephone. Interviewees were from geographically diverse programs (35% Midwest, 31% West, 19% South/Southeast and 15% North/Northeast). We identified four dominant themes about their experience: (a) skills valued in the family planning training, (b) improved patient-centered care, (c) changes in attitudes about abortion and (d) miscommunication as a source of negative feelings.

Discussion: Respondents valued the ability to partially participate in the family planning training and identified specific aspects of their training which will impact future patient care. Many of the effects described in the interviews address core competencies in medical knowledge, patient care, communication and professionalism. We recommend that programs offer a spectrum of partial participation in family planning training to all residents, including residents who choose to opt out of doing some or all abortions.

Implications: Learners who morally object to abortion but participate in training in family planning and abortion, up to their level of comfort, gain clinical and professional skills. We recommend that trainers should offer a range of participation levels to maximize the educational opportunities for these learners.

Keywords: Family planning; Partial participation; Professionalism; Residency education

1. Introduction

The Accreditation Council for Graduate Medical Education (ACGME) requires that obstetrics and gynecology residency programs provide access to abortion training. While individual programs are allowed to opt out of training due to religious or moral objections, they must find a training opportunity for their residents at another institution. Further, programs cannot require individual residents to perform induced abortions, as individual residents also have the right to opt out due to religious or moral objections. Since 1992, the proportion of residency programs with routine training has increased from 12% to 50%, and in the most recent study, an additional 40% report opt-in training and 10% no

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training [1–4]. Routine training status indicates that the training is integrated into the program as an expected component and that, in order to be excused, a resident must formally opt out.

Studies have reported that, in addition to uterine aspiration skills, residents who participate in abortion training gain other important skills such as counseling, ultrasound, analgesia and anesthesia management, miscarriage management and contraceptive skills [5]. A quantitative study of 72 opt-out residents found that they had participated in a wide range of activities during their family planning training and highly appreciated the skills they acquired. These residents also gained skills in uterine aspiration; 84% performed at least one abortion, typically for a medical indication [5]. Thus, the authors of the study conclude that it may be more appropriate to consider opt-out residents who participate in the training "partially participating" residents. Further, the norms of a particular residency program are influential in determining how residents conceptualize their partial participation. In a program with extensive routine abortion training where most residents are trained to do abortions up to 23 weeks, a resident may feel as though she has opted out when setting a gestational age limit for non-medically indicated abortions at 16 weeks of gestation. Conversely, a resident in a program with more limited abortion training may feel as though he fully participated if he did aspirations for missed abortions in the family planning clinic.

Beyond clinical procedure numbers, little is known about the experiences and perceptions of partially participating residents and their impression of the training [6]. Quantitative studies of residents who fully participated in abortion training have demonstrated that exposure leads to more accepting attitudes about abortion [3,7–9], but little is known about the effects on partially participating residents. This study employs qualitative methods to explore the experiences of ob-gyn residents who opted out of components of family planning training.

2. Methods

Between June 2010 and June 2011, we invited current and former residents who opted out of some or all of the family planning training at ob-gyn residency programs affiliated with the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning to participate in a phone interview about their experience [10]. The Ryan Program provides support to ob-gyn residency programs in the US and Canada to establish routine, integrated training in abortion and family planning. The pool of invited physicians was identified by two different Ryan Program evaluation surveys (Fig. 1): (a) In 2008, the Ryan Program conducted a quantitative survey of opt-out residents in which we asked the program faculty to forward an online survey to residents at their programs who opted out of some aspects of the training. (b) In 2011, we identified trainees via the Ryan Program's routine postrotation surveys who self-identified as having opted out and consented to be contacted for future research. Once identified, physicians from both groups were invited to participate in the interview via email.

Two interviewers conducted in-depth, semistructured interviews with residents over the phone. Interviews lasted between 20 and 40 min and covered topics ranging from skills gained during the training, interactions with faculty and peers in relation to opting out, changes in attitude about abortion and perceived benefits of the training. Participants were given a $50 Amazon gift card as compensation for their time.

The interviews were transcribed and coded using modified grounded theory with the qualitative software Atlas.ti 5.2. To generate the analysis coding scheme, the two interviewers reviewed the first 16 interviews and developed an initial code list. The code list was enhanced using an iterative process of subcoding and discussion of emerging themes. Once the code list was finalized, preliminary data were analyzed, and an additional 10 interviews were conducted to reach thematic saturation using the same interview guide. The interviewers separately coded transcripts and areas of conflict were discussed with a third researcher. Additionally, respondents were grouped based on their level of partial participation according to their responses to questions about what they did during the family planning training. The levels were (5): performed no procedures; may have observed counseling, ultrasounds or procedures, but did not participate; (4) performed no procedures but participated in contraception, counseling, ultrasounds and/or pain management; (3) did limited medically indicated cases based on personal criteria; (2) did any medically indicated cases; (1) did abortions for medical indication and/or for any indication up to a self-determined gestational limit.

This study was approved by the Institutional Review Board of the University of California, San Francisco.

3. Results

Fifty-six residents were invited to be interviewed (Fig. 1). Twenty-six physicians agreed to participate and were interviewed over the telephone, with interviews ranging in length from 18 to 40 min. Of the 30 physicians who were invited to be interviewed but did not participate, 24 were female; 5 trained in North/Northeast, 10 in the Midwest, 9 in the South/Southeast and 6 in the West. At the time of the interview invitation, 4 had completed training and 26 were current residents.

Twenty-one interviewees were female, 17 were married at the time of the interview, and the mean age was 30 (range, 27–38) (Table 1). Interviewees attended residency programs across the United States, with nine in the Midwest, eight in the West, five in the South/Southeast and four in the North/Northeast. Twenty-one interviews were with current